



Heart Fit Clinic Referral Form

Referral Form for Heart Fit Clinic Programs for Lifestyle Modification Therapy

PLEASE COMPLETE FORM – WE WILL CONTACT PATIENT FOR APPOINTMENT

Patient Information:

Last Name:	First Name:	Initial:
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Address:

City:	Province:	Postal Code:
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Phone (Home):	Phone (Work):	Phone (Mobile):
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Date of Birth (DD/MM/YR):	AHC:	Sex:
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Medical History:

Reason for Referral:

<input type="radio"/> Smoker	<input type="radio"/> Cholesterol	<input type="radio"/> Coronary Artery Disease
<input type="radio"/> Obesity	<input type="radio"/> Hypertension	<input type="radio"/> Cerebral Vascular Disease
<input type="radio"/> Diabetes	<input type="radio"/> Inactivity	<input type="radio"/> Peripheral Vascular Disease
<input type="radio"/> Post-Menopausal	<input type="radio"/> Psychosocial Factors	<input type="radio"/> Renal Disease
<input type="radio"/> Strong Family History	<input type="radio"/> Lung Disease	<input type="radio"/> Other

In my opinion, this patient should be seen in the following program:

Cardiac Rehabilitation/Maintenance – Clinically supervised exercise and lifestyle counselling for patients recovering from Acute Coronary Syndrome, CABG, PTCA, valve surgery or history of CAD, PVD, CVD, CHF, arrhythmia, recent PPM, or ICD.

Metabolic Syndrome – Clinically supervised exercise and lifestyle counselling treatment for patients with increased waist circumference and any 2 of the following risk factors; ↑ TG>1.7 mmol/L, ↓ HDL (< 1.04 mmol/L ♂, < 1.39 mmol/L ♀), ↑ BP > 130/85, ↑ FPG>5.6mmol/L.

Cardiovascular Risk Reduction – Clinically supervised exercise and lifestyle counselling for patients with severe lipids/other risk factors for chronic disease; lung or renal disease; complications of existing treatment, not reaching target guidelines; or familial/genetic disorders.

Office Address/telephone:	Signature:
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Live happier, healthier...longer.